# Attachment A.III.c.3.(c) to Family Care Waiver Application Pre-Print

# Section A: Program Impact

# Non-Competitive Sole Source Justification

# FAMILY CARE
## CARE MANAGEMENT ORGANIZATION (CMO) DEMONSTRATIONS
## NON-COMPETITIVE SOLE SOURCE JUSTIFICATION

**WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES**
**REVISED JANUARY 2001**

## INTRODUCTION AND BACKGROUND

Family Care is an important long term support initiative in Wisconsin that will:
- Increase access to community-based care among elderly people and people with disabilities through a single entry point in each county, the Aging and Disabilities Resource Center;
- Provide cost-effective service delivery through Care Management Organizations; and
- Ensure an exceptionally high quality of care and improved consumer outcomes.

Building on more than twenty years of community-based long term care in Wisconsin, the Department of Health and Family Services plans to contract with six Family Care pilot counties to implement the Family Care demonstration.

Counties have been responsible for providing case management and arranging for community supports for Home and Community Based Waiver participants since 1986. Prior to that, Wisconsin counties implemented the nationally recognized and innovative Community Options Program, a State initiative that diverted people from high cost institutions.

Wisconsin is seeking a combined 1915 (b)/1915 (c) waiver, which, in the pilot counties, will allow the State to offer Home and Community-Based waiver services only through the Family Care CMO. In these pilot counties, people who are eligible for Home and Community-Based waivers will still be offered the choice of institutional care or community care, but if they choose community care, they will only be able to receive waiver services under the b/c waiver through the Family Care CMO. Pending HCFA approval, the b/c waiver will be effective July 1, 2001.

Enrollment is voluntary and the enrollee may disenroll at any time. The CMO will operate under a Pre-Paid Health Plan (PHP) contract with the Department of Health and Family Services. The PHP is a less than comprehensive ???Medicaid managed care contract. Wisconsin is submitting this sole source justification in order to seek HCFA approval of the sole source contracting with the pilot counties to be Family Care CMOs.

The remainder of this sole source justification answers HCFA's questions about sole source contracting with Family Care pilot counties.

# PART A: COMPETITIVE PROCUREMENT

- **What criteria did the State use for determining that a competitive procurement process was impractical?**

Wisconsin determined that competitive procurement is impractical at this time because of the need to ***transition*** from our current county-based system to a competitive environment. From the fall of 1995 until the final Family Care Proposal was issued in July 1998, Wisconsin worked closely with consumers and advocacy groups to ensure high acceptance among consumers of both Family Care and the organizations with whom the Department would contract to deliver services. Mechanisms for involving consumers included focus groups (which helped shape the goals of the effort to redesign our system), Steering Committees, work groups to develop and negotiate policy, and a number of consumer forums held around the state. Consumers and advocates wanted counties to be the responsible long term care managers for many reasons, including:

- **Continuity of care as we transition to a new system**. Consumers are worried that change in the delivery system may result in lack of continuity of care. People with long term care needs are not easily transitioned to new providers as healthy people switching from one HMO to another might be. People who have chronic conditions and severe disabilities cannot wait for the paperwork to clear before someone is assigned to put together a care plan. Counties have always been responsible for delivering all community-based long term care services to elderly, people with physical disabilities and people with developmental disabilities.

- **A high level of county staff knowledge and experience** in meeting consumer needs through local social and long term support systems. Consumers are concerned that outside organizations coming into the county will lack this knowledge. We know that family relationships and neighborhood and community connections are key to consumer satisfaction with long term care services, and we must be responsive to this demand as a measure of quality performance.

- **Local administrative and public oversight** by county government and by local planning councils, a majority of whose members are consumers and their families and other representatives. Consumers are dismayed at the idea of an organization owned by a corporation in another state doing the very personal business of long term care - bathing, grooming, toileting - in their county with no public local oversight to ensure the responsiveness and quality of the delivery system.

In early 1998, the Wisconsin State Legislature, in language included in the state's annual budget review bill, directed the Department to contract with counties to pilot Family Care's new delivery system, the Care Management Organization (CMO). By spring of that year, the Department was ready with a Request for Consideration to seek applications from Wisconsin counties to become CMOs. This selection process followed to the letter the State's procurement rules and met every requirement of competitive procurement except that the types of applicants were limited to counties and tribes, based on both consumer demand and legislative direction.

Wisconsin is committed to using open competition to select long term managed care contractors after a period in which providers in the current delivery system are allowed to gain the capacity to compete effectively with private providers and consumers are able to gain a level of comfort that the State's monitoring and oversight role will result in continuity and quality of care, regardless of care management provider.

Legislation included in the 1999-2001 Biennial Budget Bill recently passed by the Legislature, grants the Family Care pilot sites a period of protection against competitive procurement. The Legislature wants to ensure that the Family Care pilot counties have ample time to implement Family Care and demonstrate their ability to meet performance standards before the counties are required to compete. The bill establishes the timeline that counties have to implement Family Care without competition as follows:

- No competition for Family Care pilots in calendar year 2000, when the counties are operating under the State's current 1915(c) waivers and a HCFA approved pre-paid health plan contract in a totally voluntary system.

- No competition for Family Care pilots i during the initial period of the Family Care 1915(b)/(c) waiver.

- If the Family Care pilots demonstrate that they are meeting performance standards set forth by the Department of Health and Family Services, there will be no competition in calendar year 2003, during year 1 of the first waiver renewal of the 1915(b)/(c) waiver . If the pilot cannot demonstrate the capacity to serve all people who are eligible and entitled to the Family Care benefit in the service area, the Department may contract with an additional organization to provide the Family Care benefit in 2003; and

- Then beginning in year 2 of the 1915(b)/(c) waiver renewal, all Family Care CMO contracts will be selected on a competitive basis, which will focus on quality of care, not the lowest bidder.

Wisconsin strongly believes the approach we have taken to competitively select counties to pilot Family Care and to move slowly but intentionally toward full open competition is in the best interests of consumers of the State's long term care services. We understand the Federal position that competition results in the selection of the most qualified providers, which of course is in the consumer's interest. However, during this transition period to Family Care, it is not only the counties that are learning a new way of doing business. The state must also develop and test its systems for contracting, financing, quality oversight and improvement.

In the best interests of consumers, the State is already working with the selected Care Management Organizations to:

- Develop quality indicators and performance measures, including performance-based contracts;
- Provide extensive assistance to the CMOs in developing information systems to meet the Department's encounter reporting requirements;
- Develop, test and evaluate the Department's systems for quality oversight; and
- With consumer and advocacy input, implement and improve grievance and appeals systems.

All of these efforts to improve CMO quality and the State's contracting and oversight should assure HCFA that even without immediately going to completely open competition, Wisconsin will have other mechanisms in place to assure that the expected outcome of competition - the highest consumer quality possible - will occur.

- **What type of public process did the State use to identify potential bidders?**

Given their long experience in delivering services to elderly people and people with disabilities in Wisconsin and performing many of the roles envisioned for the new long term care system, and given the legislative directive mandating counties and/or tribes to demonstrate their ability to manage long term care programs, all 72 Wisconsin counties and 11 tribes had the opportunity to submit a response to the Department of Health and Family Services "Request for Consideration to be a Care Management Organization Demonstration."

Of Wisconsin's 72 counties and 11 tribes, 18 proposals were submitted, representing 21 counties and 4 tribes. After a thorough screening by 8 evaluators as well as reference checks, 11 counties were selected to participate in the Care Management Organization demonstration phase of Family Care. Fond du Lac, Kenosha, LaCrosse, Marathon, Milwaukee, Portage, Richland, and Waukesha counties and the multi-county consortium of Forest, Vilas and Oneida counties were selected to be Care Management Organization demonstrations. Of those, only Fond du Lac, LaCrosse, Milwaukee, Portage, Richland and Kenosha will participate during the initial waiver period.

These counties were selected to pilot Family Care because their proposals demonstrated that they had the knowledge, skills, and infrastructure necessary to develop a Care Management Organization. The selected counties also have a balance of the target populations being served in Family Care, have adequate representation of consumer responsive methods, are geographically distributed, and have a mix of urban and rural populations.

- **Did the State determine that only one entity would bid? How was that determination made?**

The Wisconsin Legislature mandated that only one **type** of entity -- counties and tribes -- would be allowed to apply to be Care Management Organization demonstrations for Family Care. The mandate specifically directed the Wisconsin Department of Health and Family Services to contract with counties or tribes for pilot projects to demonstrate the ability of counties or tribes to operate care management organizations for the delivery of long term care services and is why the Department of Health and Family Services issued its "Request for Consideration to be a Care Management Organization Demonstration". The entities that were eligible to respond to the Department's "Request for Consideration to be a Care Management Organization" were Wisconsin counties, Wisconsin tribes, or any consortium made up of two or more Wisconsin counties and/or tribes.

The Wisconsin Legislature mandated that prior to July 1, 2001, the Family Care Program will be limited to a pilot program in areas of the State that would not exceed 29% of the eligible population. Then after June 30, 2001, the Department of Health and Family Services would need legislative approval to expand Family Care beyond this 29%.

Counties and tribes play a critical role in Wisconsin's long term care system, which is supervised by the State and administered by the counties. The Counties and Tribes manage a variety of home and community-based programs for people who need long term care, including the Community Options Program and Medicaid home and community-based waiver programs, which are the major case managed long term care programs currently in existence. County governments also have statutory responsibilities for providing services to people with developmental disabilities or mental illness and other vulnerable adults. Many long term care consumers are involuntary clients who have dual diagnoses and are challenging to serve. Because county and tribal agencies are responsible for planning and contracting for services for such people, complex treatment plans are implemented despite the time or fiscal factors that have led some private agencies to avoid or exclude them.

A publicly elected Board uniquely ties the county human service and social service agencies to their communities. Staff are long time community residents and knowledgeable about the local formal and informal delivery system. Counties and tribes have established networks of home and community-care providers, which provide a basis for an expanded network for the broader Family Care benefit. Although not all counties provide health care services directly to long term care consumers, they do provide care management and contract with community-based service providers.

In summary, the county and tribal long term support agencies have the following strengths as the historical providers of long term care services in Wisconsin:

- Experience in designing service packages to meet individual needs, in providing consumer-oriented community-based services and in working cooperatively with medical systems.

- Experience in designing and delivering services that promote consumer participation and choice, and availability of long term support staff trained in values of consumer-centered approach to care management. These ties to local communities facilitate use of informal supports and of natural unpaid supports. This high level of flexibility in designing plans ensures cost effectiveness and choice, and helps consumers sustain significant relationships.

- Ability to tailor program policies and procedures and to develop provider networks to meet unique demographic and cultural needs of the local population. Both urban and rural areas have particular ethnic communities. Rural programs have fewer formal resources but have developed strong informal supports, creatively coping with the lack of public transportation and otjer resources by developing informal supports and volunteers, while urban programs depend on more formal resources and brokering.

- Experience with quality assurance methods for Medicaid waiver programs, with the goal of promoting optimal outcomes in a cost-effective manner, including prevention and early intervention.

- Experience with a care management model of service delivery in the state-funded Community Options Program and HCBW programs, which uses a care manager/participant team as the focal point, with the care manager responsibility for assessment, care planning and arranging services in a cost-effective manner. Counties are at risk since county levy dollars are used if the county exceeds its state allocation. Agencies are skilled at assessing

needs and providing community-based care plans with limited budgets, and at averaging dollars and absorbing high cost consumers within the system at the local level.

– Experience in serving all LTC populations, and in developing appropriate and cost-effective services and recruiting service providers. In spite of state-wide shortages of personal care and chore workers, county/tribal agencies have found ways to continue to provide care in participants' homes. Experience with sub-contracting and resource development for a wide range of services.

– Current capability to provide long term care and health care services, by building on the current provider and service network. In home care providers, nursing services, and care management are in place, counties have capacity to provide, through contract, residential, recreational and employment services as well as assessment, care planning and on-going monitoring. Systems are in place to utilize volunteers, a variety of service agencies and to sustain natural supports.

- **Did the State conduct a cost-analysis to assess if a competitive procurement process would be practical? What were the results?**

Since the Care Management Organization Demonstrations for Family Care will move towards a competitive procurement process in the near future, the Department of Health and Family Services has not conducted a cost-benefit analysis. The Department of Health and Family Services did prepare a Family Care Cost Model. This model projected the costs of Family Care starting with the demonstration phase and continuing through to statewide implementation. There was also an extensive public process for consumers and other stakeholders to comment on the Cost Model several times during its development. Note also that the Family Care statutory language directs the Department to contract with an additional organization starting in CY 2003 if the pilot cannot demonstrate capacity to implement the entitlement to Family Care.

- **What criteria will the State use in the future to determine the continued use of a contract that was awarded without going through a competitive procurement process?**

Wisconsin will use a pre-paid health plan contract, the Health and Community Supports contract, to contract with the Family Care pilot county CMOs. A draft of this contract was submitted to HCFA in December 1998, and reviewed by HCFA officials who provided verbal feedback that the contract is compliant with the 1997 BBA managed care requirements. A revised contract is being submitted to HCFA, along with this Sole Source Justification, for final approval so that Wisconsin can contract with CMOs to pilot Family Care starting January 1, 2002.

The Health and Community Supports contract includes State and Federal standards for the Care Management Organizations for Family Care as well as quality and performance standards identified by the Department of Health and Family Services with input from consumers and other stakeholders. Input from consumers, their families and other stakeholders has been and will continue to be gathered in a variety of ways including public meetings and forums and participation in work groups formed to work with Department staff to develop policies for the new program in specific areas.

Department staff are preparing self-assessment baseline surveys for the CMOs to use to prepare for certification. The surveys guide the CMOs through the certification requirements in three areas: quality, provider contracting and fiscal. In addition, the Health and Community Supports contract includes required reports and data submissions so that the State can measure performances on specific quality performance measures. These measures were initially developed by consumers and were further developed by a workgroup of State and CMO staff.

The Family Care contract standards address participation, prevention, consumer satisfaction, QA/I programs and projects, and cost effectiveness. If the CMO does not meet the contract standards by demonstrating an acceptable level of quality performance and consumer protections, the Department will not continue to contract with the Care Management Organization. By July of 2000, local long term care councilsthat are established in the Family Care legislation, consisting of at least 51% consumers qand heir representatives, also will start to advise the Department on local satisfaction with the level of performance of the CMOs. If a CMO is meeting performance standards by the end of 2002, it will not have to compete for another year.

## PART B: LIMITING BENEFICIARY CHOICE

- **Describe the Provider Network (Current and Proposed)**

The Family Care CMO demonstration counties already operate a highly respected and effective Home and Community Based Waiver program in Wisconsin. The counties have considerable experience contracting for home and community based services, which includes an extensive array of benefits. To be certified as a Family Care CMOs all will need the capacity to provide all of the services in the Family Care Benefit Package that are currently provided on a fee for service basis, i.e., the Medicaid State Plan services that are included in the Long Term Care benefit package. The CMO may use providers that:

- Are certified by the Medicaid program for those services in the LTC benefit package that would have been provided under Medicaid fee-for-service;
- Meet the provider standards in Wisconsin's Home and Community Based Waivers;
- Meet the CMO's provider standards, which are approved by the State.

By the effective date of the Health and Community Supports Contract, the Care Management Organization demonstrations will be required to demonstrate to the Department of Health and Family Services an adequate capacity to provide the projected membership with:

- An appropriate range of services;
- Access to prevention and wellness services;
- A sufficient number, mix and geographic distribution of subcontractors of services
- Specialized expertise with the target population(s) served by the Care Management Organization;
- Culturally competent providers;
- Services accessible within a timeframe to meet the needs of the members; requests for advance authorization shall be responded to within 14 days; and
- Services that are physically accessible, are within reasonable distance/travel time, that have convenient hours of operation, and are available on a timely basis.

The local Long Term Care Council will oversee and advise on the adequacy of the provider network. The Department of Health and Family Services has requested that the Family Care statutory language allow the Counties to phase in the development of this Council.

- **Are any provider types excluded? Identify the types and reason for exclusion.**

Yes, the Care Management Organization demonstrations are not required to provide the following Medicaid covered services, which will remain available on a fee-for-service basis to Care Management Organization enrollees:

- Alcohol and Other Drug Abuse Services from a Psychiatrist or in an Inpatient;
- Audiology;
- Chiropractic;
- Dentistry;
- Medical Emergency Care (including air and ground ambulance);
- Hospital: Inpatient and Outpatient (except therapy services delivered in an outpatient setting);
- Lab and X-Ray;
- Optometry (including eyeglasses);
- Pharmaceuticals;
- Physician and Clinic Services;
- Podiatry;
- Psychiatric Services from a Psychiatrist and Inpatient psychiatric services.

During 1996 to 1998 while the Department was developing the Family Care Proposal, consumers expressed extreme concern about integrating acute care into the Family Care benefit. Consumers felt that acute and primary health care systems tend to drive decision-making about social supports and overwhelm social supports when that may be the only service that an elderly person or person with disabilities needs. In response to these consumer concerns, Care Management Organizations will not be required to provide acute and primary health care services. The CMOs will be required to form linkages with providers of the services that remain fee-for-service in order to ensure the appropriate coordination and continuity of care that is needed by people with special health care conditions. An additional purpose of these linkages is to prevent cost shifting to the fee-for-service system. The Department will closely monitor both continuity of care as CMO members move between the long term support and the acute/primary health care systems, as well as the utilization of acute and primary health care services.

- **How many and what types of providers (primary care, specialty and subspecialty) are furnishing care currently?**

See the Health and Community Supports Contract (beginning on page 14) for the list of services in the Family Care Benefits Package. See also the lists of the current provider contracts for each Care Management Organization demonstration county. These lists include all the contracts each county currently has with providers of various long term care services. Care Management Organization demonstrations will need to expand their provider networks to include those additional services that are in the Family Care benefit package, but which are not part of the counties' current long term care programs.

- **What is the current ratio of case management providers to beneficiaries?**

Note: Physicians are not included in the Family Care benefit. Therefore, this question has been revised to reflect the nature of the Family Care program.

The Department has established the following standards for use in calculating case manager to participant ratios:

- Direct case management services require 2.5 hours per month per participant;
- Each assessment and each care plan requires 7 hours of case management time.

This standard results in an approximate ratio of 1:40 case managers to clients. In addition, the current Home and Community Based Waiver programs have case management requirements for amount and frequency of contact with participants, including:

(1) For elderly and people with physical disabilities, case managers shall have either a BA/BS degree in a health or human services related field or four years experience working as a long term support care manager, or a combination of training and experience that equals four years, and provide:
   - Monthly contact either directly with the participant or with a family member, medical or social service provider, or other person with knowledge of the participant's long term care needs;
   - Face to face contact with participant every three months;
   - Review of plan of care with participant every six months. Direct participant contact every other month.

(2) For people with developmental disabilities, case managers shall have human services degree and two years experience in the developmental disabilities field, and provide:
   - Monthly contact with a family member, medical or social service provider, or other person with knowledge of the participant's long term care needs;
   - Direct participant contact every three months.

- **What will the ratio of providers to beneficiaries be under the contract?**

The contract between the Department and the Care Management Organizations specifies the use of a team-based case management approach, and requires those teams to identify, with the consumer, the specific outcomes that the team will be working toward for and with the consumer, but does not specify particular ratios of case management providers to beneficiaries.

The case management team must, at a minimum, consist of a social service coordinator and a registered nurse, and must utilize appropriate additional specialized expertise as needed. The social service coordinator is required to have a minimum of a four-year bachelor's degree in the social sciences area (e.g. social work, rehabilitation psychology, etc.), except that current county long term care case managers who do not have degrees will be permitted to serve as a member of the Care Management Team. It is expected that Care Management Organizations will want to include on the care management teams individuals who do the routine scheduling and paperwork, freeing up the nurse, social service coordinator, and other experts as needed to work more directly with consumers.

Besides working toward the consumer outcomes identified in the individual service plan, the care management team will be contractually responsible for the following outcomes:

- Completing, with the member, the comprehensive assessment and the individual service plan; timelines and standards for both are included in the contract;

- Arranging for the provision of all services in the long term care benefit package, based on the individual service plan;

- Arranging for services that are not covered in the long term care benefit package, and instructing members on where and how to obtain them, including how transportation is provided;

- Reviewing and updating the individual service plan as the member's condition, needs, and desired outcomes change or as the plan fails to achieve the planned outcomes.

The Care Management Organizations are demonstrations of a new model for health and long term care delivery in Wisconsin. As demonstrations, they will be developing information about both the amount of overall team care management required to achieve the desired outcomes, for what types of consumers. Even more specifically, they will be developing information about the appropriate mix of time by different team members. The Department will be able to report this information to the Health Care Financing Administration, if desired.

- **How accessible will the contractor be in terms of:**
  - Travel times and distance -- The Care Management Organization must develop standards for timeliness of access to services in the LTC benefit package and member services that meet or exceed such standards as may be established by the Department of Health and Family Services.

  - Obtaining appointments -- The State will ensure the Care Management Organization will establish timeliness standards for appointments. Such standards will include criteria for the classification of requests for services by level of urgency and will take into consideration in-office waiting times for each type of service in the Family Care Benefit Package, the immediacy of member needs and common waiting times for comparable services in the community.

  - Waiting times in provider offices -- Since the Family Care benefit package does not include primary or acute care services; there are relatively few services in which the client would go to an office. For the providers they will see in an office, there will be no changes in wait time from the fee-for-service program.

  - 24-hour, 7 days a week access -- The CMO shall be responsible 24 hours each day, seven days a week for providing members with access to services in the long term care benefit package, coordination of services that remain Medicaid fee-for-service, and linkages to Adult Protective Services.

- Translation services -- The CMO shall provide interpreter services (American Sign Language as well as non-English Language) for members as necessary to ensure availability of effective communication regarding treatment and service plans, medical and psychosocial history or health education about health and long term care issues.

- **How will beneficiary free choice of providers be maintained?**

The Care Management Organization Demonstrations for Family Care are voluntary managed care programs. Consumers will enter the long term care system through the Aging and Disability Resource Centers, the single point of entry for accessing all long term care services. If an individual meets the eligibility criteria and he or she decides to seek long term care services, the Resource Center will refer the potential enrollee to an enrollment counseling service contracted for by the state independently of any CNO, Resource Center or other service provider. The enrollment counselor will inform potential enrollees about the full range of provider choices available to them including free choice of Medicare, Medicaid and other providers that remain fee-for-service. The enrollment counselor will review member rights with potential CMO enrollees.

These member rights include the right to choose providers from outside of the Care Management Organization's provider network for services that involve intimate personal needs or involve coming into the home frequently. The Care Management Organization must establish a process to allow the member to use their chosen provider for services that involve intimate personal needs or involve coming into the home frequently given the providers meet the established criteria.

The Care Management Organization also will be required to consider a member's request for a provider who does not have an agreement with the Care Management Organization to provide services in the Family Care benefit package to members. The Care Management Organization will arrange for services from these providers if the member's request is authorized. Instances when the member's request for a provider outside of the Care Management Organization's provider network may be warranted when:

- The Care Management Organization does not have the capacity to meet the need
- The Care Management Organization does not have the specialized expertise, specialized knowledge or appropriate cultural diversity in its network of providers
- The Care Management Organization can not meet the need on a timely basis
- Transportation or physical access to the Care Management Organization providers causes an undue hardship to the member.

- **How will beneficiary choice and access be maintained if the beneficiary wants to disenroll from the contracted entity?**

Since Family Care is a completely voluntary program in calendar year 2000, the beneficiary can disenroll at any time without cause and receive services through the fee-for-service system or a nursing facility. When an individual tells the CMO that he/she wishes wish to disenroll, that individual will be referred back to the independent enrollment counselor for additional choice counseling, and to the Resource Center for options counseling to ensure the consumer's care needs are met.

- **Describe the Quality Improvement Plan**

The quality improvement plan will focus on systematic quality improvement by promoting continuous quality improvement above and beyond the minimum standards contained in the PHP contract and the CMO's own standards. The basic elements of the quality assessment and performance improvement program for CMOs are minimum performance levels on standardized quality measures and annual performance improvement projects. Each CMO is required to measure its own performance, using standard measures required in the PHP contract; report its performance to Department; and achieve any minimum performance levels that the Department establishes on those standard measures. The standard measures are specified in uniform data collection and reporting instruments.

During the first contract year, each CMO will conduct one performance improvement project that focuses on at least one of the Family Care consumer outcomes. The project will involve measuring performance, implementing system interventions, evaluating the effectiveness of the interventions, and planning for sustained or increased improvement. Within the focus area, the CMO selects its own topic for measurement and improvement, so that it can conduct a project that relates to aspects of care and services that are significant for its own population. The Department will gradually increase the number of performance improvement projects through the general contract negotiation process.

On an annual basis, the Department will assess the impact and effectiveness of each CMO's quality assessment and performance improvement program. The review will include the CMO's performance on the standard measures, on which the CMO is required to report, and the results of the CMO's performance improvement project. In addition, the Department requires that each CMO have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program.

- **What are the Quality Improvement (QI) Standards?**

The quality improvement standards include access standards and other standards that relate directly to the improvement of quality of care and services (e.g., grievance procedures). Specifically, the QI standards define the requirements of an internal quality assessment and improvement program in a prepaid health plan (PHP) arrangement, specify structure and process standards for administrative aspects of the plan, and assure basic consumer protections (e.g., enrollee informing materials, policies on enrollee rights). The standards form a threshold for participation and help assure that the contractor addresses the needs of all enrollees.

- **How will the standards be measured?**

The contracting organization is required to continuously monitor and assess its resources and administrative systems and the activities it performs on behalf of its enrollees (e.g., assuring availability, accessibility, and quality of care) and provide feedback on its own performance and the performance of affiliated providers. Contractors will collect and report data on performance using standardized outcome measures and enrollee satisfaction. Performance measures are developed as part of the process of negotiating the contract. Performance data are used to provide

comparative information on factors that are important to consumers such as choice, convenience, quality and benefits.

- **What data will be collected and how will it be used for continuous Quality Improvement?**

Data will be collected from a variety of sources, i.e., service and clinical records, transaction files, and consumer and provider surveys. Contractors are required to carry out performance improvement projects within the organization on an annual basis. These activities must emphasize and demonstrate improvement in outcomes. Each contractor is required to collect baseline data on a focused area of concern, implement appropriate interventions, evaluate results and achieve improvement in outcomes over time.

- **What kinds of clinical studies will be done and how will the results be used?**

Each contractor will select one QI project per year that pertains to one of three focus areas of concern. The focus areas are 1) member self-determination and choice, 2) member involvement in the community, and 3) health and safety. The contractor then selects a topic for study that reflects the characteristics and needs of a significant portion of the enrolled population and relates to an outcome of care. Findings will be used to improve the health, functional status and satisfaction of enrollees.

- **What quality criteria will the sole source contractor use to determine provider participation?**

Each contractor must implement a provider selection process. The process must include procedures for approving the provider, including a written application, verification of licensure and other information from primary sources, and site visits as appropriate, and procedures for reassessing provider qualifications, at least every two years. The reassessment procedure must consider performance indicators collected through the internal quality improvement program, the utilization management system, the grievance system, enrollee satisfaction surveys, and other activities of the organization. Thc contractor must also have written policies and procedures for suspending or terminating affiliation with a participating provider, including an appeals process.